DSS-106A-2
10/90

MEDICAL APPOINTMENT

Today's Date: _____

CHILD'S NAME: _____ **DOB:** _____

MEDICAL APPOINTMENT

Reason for today's appointment:

_____
_____
_____
_____
_____
_____

RX. prescribed:

_____
_____
_____

Is follow-up appointment needed?

Yes _____ No _____

If Yes, please describe:

_____
_____
_____
_____
_____
_____
_____

Provider Signature

_____

Address:

_____
_____

Phone:

_____

GENERAL SCREENING

Height	
Weight	
Temperature	
Pulse	
Nose	
Mouth	
Teeth	
Speech	
Heart	
Chest	
Abdomen	
Extremities	
Skin	
Posture (Spine)	
Neuro/ Reflexes	
Breast	
Genitalia	
Other	
Other	
Other	
Other	
Other	
Other	

GENERAL SCREENING

Vision	Left	Right	Both
Hearing	1000	2000	4000
(Right)			
(Left)			
HGB/HCT			
Urine Dip Stick	Culture		
	Dip Slide		
Blood Sugar	Method		
	Results		
Sickle Cell			
Rubella Titer			
Antibody Screening			
RH Factor			
Sputum	Smear	Culture	

SEXUALLY TRANSMITTED DISEASES

VDRL		
OTHER	Culture	Smear

File: Original, Passport Folder
Copy, Professional, Section III.